

Welcome!



PATIENT INFORMATION

Date: _____

Name: _____

Birth Date: _____ Age: _____ Sex: _____

Address: _____ City: _____

State: _____ Zip: _____

RESPONSIBLE PARTY

Name of Person Responsible for the Patient: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Employer: _____ Social Security Number: _____

Insurance Co: _____ Plan Number: _____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

- | | | | | | |
|---|---|--------------------------|---|---|--------------------------|
| Y | N | Allergies to any drugs | Y | N | Diabetes |
| Y | N | Any Hospital Stays | Y | N | Seizures/Epilepsy |
| Y | N | Any Operations | Y | N | Handicaps/Disabilities |
| Y | N | Heart Defects | Y | N | Cerebral Palsy |
| Y | N | Asthma/Lung Problems | Y | N | Developmental Delays |
| Y | N | Hepatitis/Liver Problems | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Kidney Problems | Y | N | Cancer |
| Y | N | Bleeding/Blood Problems | Y | N | Autism Spectrum Disorder |
| Y | N | Heart Murmurs | Y | N | Tuberculosis |
| Y | N | Down Syndrome | Y | N | ADHD |

Please discuss any medical problems that the child has/had: _____

Has your child ever been diagnosed with a Syndrome? Y N If yes, please explain: _____

Child's Physician: _____ Phone Number: _____

Is the child currently under the care of a physician: Yes No Date of last visit: _____

Please describe the child's current physical health: Excellent ____ Good ____ Poor ____

Please list all medications the child is currently taking: _____

Please list all allergies the child has, including medications: _____

What is your child's favorite character/toy/movie: _____

Who can we thank for referring you to our office: _____

What is the best way to contact you: (please check all that apply)

_____ home phone _____ cell phone _____ e-mail _____ text message

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and is my responsibility to inform the doctors at Encino Pediatric Dental Group of any changes in my child's medical status at the earliest possible time.

Signature

Print Name

Doctor Signature

Date



Dental Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to dental malpractice, that is as whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the dentist (Encino Pediatric Dental Group, Drs. Joseph Curtin & Parnaz Mansouri) and the dentists' partners, associates, associations, corporations, corporation of partnership, and employees, agents and estates of any of them, must be arbitrated including, without limitation, including but not limited to all claims or personal injury, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the dentist or patient to collect or contest any fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not, the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the investigation and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, upon such intervention and joinder any existing

court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgments or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrators.

Article 4: General Provisions: All claims based upon the same incidence, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the dentist within 30 days signature. It is the intent of the agreement to apply to all medical and dental services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services: _____ Patient's or Patient's Representatives initials

If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I understand this.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED NY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

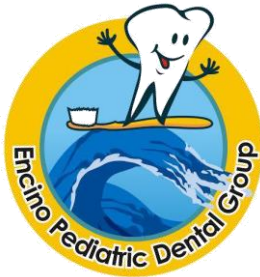
By: _____
Dentist's or Dentist's Representative Signature/Date

By: _____
Print or Dentist's Stamp Name of Office

By: _____
Patient's or Patient's Representative's
Signature/Date

By: _____
Print Patient's Name

If Representative, Print Name and
Relationship to Patient



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____ Your Name: _____

_____ Relationship to Patient: _____

_____ Signature: _____

_____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____



Consent for Dental Treatment

1. I, as the legally responsible parent/guardian of _____, hereby authorize Encino Pediatric Dental Group, Drs. Joseph Curtin & Parnaz Mansouri, the dentists, and their dental assistants as may be selected to complete treatment plan as described by the dentists.
2. I agree to have an exam, cleaning, fluoride treatment, and x-rays completed as deemed necessary by the dentist for my child.
3. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s).
4. I have been informed of possible alternative methods (if any), including no treatment at all and the risks of non-treatment. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have, and that this treatment is intended to provide improved dental health and prevent future potential problems.
5. The dentists and/or his employees have explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that such treatment risks include, but are not limited to, the following:
 - a. Possible postoperative discomfort and swelling.
 - b. Possible biting of lip and tongue while anesthetized causing discomfort and swelling.
 - c. Possible stretching of corners of mouth with possible cracking of lips.
 - d. Possible decision to leave small piece(s) of root in jaw if tooth is extracted and if removing root tip would require extensive surgery or damage to permanent tooth.
 - e. Possible prolonged bleeding following tooth extraction.
 - f. Possible damage to adjacent teeth or restorations during procedure.
6. It has been explained to me that, during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I therefore authorize and request that the dentists perform such procedures as are necessary and desirable in the exercise of their professional judgement. This authorization shall extend to the treatment of all conditions that require treatment and that are not known at the time of the original procedure started.
7. I consent to administration of nitrous oxide/oxygen analgesia, topical and local anesthesia in connection with the procedure(s) referred to above.
8. It has been explained to me, and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
9. I understand that estimated insurance co-payments are due at the time of treatment, but that additional payment may be required when we receive an explanation of benefits from your insurance.
10. I certify that I read and write English and have read and fully understand this consent for treatment.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT BEFORE YOU SIGN.

PARENT OR LEGAL GUARDIAN SIGNATURE

DATE

WITNESS (DENTIST OR STAFF MEMBER)

DATE

16550 Ventura Blvd., Suite 322, Encino, CA 91436
Phone: (818) 849-5457 Fax: (818) 849-5009
encinopediatricdentalgroup@gmail.com www.encinopediatricdentalgroup.com



CONSENT FOR BEHAVIOR MANGEMENT TECHNIQUES

Tell-show-do • Tell-show-do involves verbal explanations of procedures in phrases appropriate to the developmental level of the patient (tell); demonstrations for the patient of the visual, auditory, olfactory, and tactile aspects of the procedure in a carefully defined, nonthreatening setting (show); and then, without deviating from the explanation and demonstration, completion of the procedure (do).

Voice control • Voice control is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.

Nonverbal communication • Nonverbal communication is the reinforcement and guidance of behavior through appropriate contact, posture, facial expression, and body language.

Positive reinforcement • Positive reinforcement is an effective technique to reward desired behaviors and, thus, strengthen the recurrence of those behaviors. Social reinforcement include positive voice modulation, facial expression, verbal praise, and appropriate physical demonstrations of affection by all members of the dental team. Nonsocial reinforcement include tokens and toys.

Distraction • Distraction is the technique of diverting the patient's attention from what may be perceived as an unpleasant procedure. Giving the patient a short break during a stressful procedure can be an effective use of distraction prior to considering more advanced behavior guidance techniques.

Molt Mouth Prop • The mouth prop allows us to keep your child's mouth open during dental procedures so that his/her mouth will not tire.

Patient's Name: _____

Parent's Signature: _____ Date: _____

Parent's Name and relationship to child: _____